

Millville Public Schools

Sports Physical Form

2014-2015



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Millville Public Schools
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Millville Senior High School
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Millville, NJ 08332

Memorial High School
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Millville, NJ 08332

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2 North Sharp Street
Millville, NJ 08332
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Middle School Athletic Coordinator

Frequently Asked Questions About Sports Physicals

What is a “Sports Physical”? A “Sports Physical” is actually an Athletic Pre-Participation Evaluation which is mandated by the New Jersey Department of Education. It is required for all students in grades 6 – 12 who want to participate in athletics and some competitive clubs. A physician, advanced practice nurse or physician’s assistant must examine the student and review the health history to determine whether or not the student may participate in sports with (or without) limitations. The Athletic Pre-Participation Evaluation will then be sent to the School Physician. He/she will provide written notification to the parent stating approval or disapproval of the student’s participation in athletics based upon the medical report (This process can take up to 10 days).

Where do I get the Sports Physical Form? A form is included in this packet. Additional packets are available in the Main Office at your child’s school.

Who completes the Sports Physical Form? The form consists of 4 pages. The first page is a health history that must be completed and signed by the student’s parent/guardian. The second page is ONLY completed for student-athletes with special needs. The remaining 2 pages must be completed by a physician, advance practice nurse or physician’s assistant.

How long is a Sports Physical good for? A Sports Physical is good for 365 days from the date of medical examination. **If the examination is completed more than ninety (90) days prior to the first practice session, the student is required to complete a Health History Update Questionnaire.** This form is available at the student’s school and must be completed/signed by the parent/guardian. The Health History Update Questionnaire does not need to be signed by your healthcare provider.

Once my child’s Sports Physical Form is completed, what’s next? Completed Sports Physical Forms should be given to the SCHOOL NURSE at your child’s school. Do not give the form to your child’s coach, homeroom teacher or any other person in the school. The school nurse will review the form for completeness. Incomplete forms will be returned to the student. Completed forms are forwarded to the School Physician as described above.

What should I do if my child has asthma, a significant allergy or some other health issue requiring the use of medication? In the event that the student has asthma, an allergy that requires the use of medication or other health condition requiring intervention, the student must provide a written order from his/her healthcare provider for the management of this condition. The Sports Physical Form will **not** be forwarded to the School Physician until all documentation is provided to the school nurse.

How will I know when my child is medically cleared to participate in a sport/activity? The school nurse will send a letter home indicating the School Physician’s determination.

How will I know when my child is academically cleared to participate in a sport/activity? (High School students only). The Athletic Director is responsible for clearing students academically. Please have your child check with his/her coach to see if he/she is academically cleared to participate.

PLEASE KEEP THIS PAGE FOR FUTURE REFERENCE

Illnesses/Injuries During the Sport/Activity Season

If a student is injured during a game/practice:

1. The student must notify his/her coach or activity advisor **immediately** when an injury occurs during a game or at practice. The coach/advisor will assist the student in receiving medical evaluation/care. The student may receive care from the Athletic Trainer, be referred to his/her own health care provider or in emergency situations, the emergency department. Students injured during school sponsored activities are covered by a secondary insurance purchased by the Millville Board of Education. The School Nurse or Athletic Trainer can give you more information about this insurance.
2. In the event that a student discovers he/she is injured **after** a game/practice, the student must notify his/her coach, Athletic Trainer, and school nurse as soon as possible. If the coach is not available, notify the Athletic Director (High School students) or the Athletic Coordinator (Lakeside Students) and the School Nurse.
3. When the student returns to school following the injury, he/she should report immediately to the School Nurse. All paperwork given to the student from his/her healthcare provider or emergency department should also be given to the nurse. The nurse will review the instructions given to the student and implement any necessary accommodations. The nurse will share this information with the Athletic Trainer who may coordinate additional care.
4. **The student may not resume sports/activities until medically cleared in writing by his/her healthcare provider.** This information must be provided to both the School Nurse and Athletic Trainer. This information will then be forwarded to the appropriate coach.
5. Students may not attend school on crutches without a written doctor's order or an order from the emergency department.
6. **Students are reminded NOT to give doctor's notes directly to their coaches.**

Illnesses:

1. All illnesses requiring a visit to your healthcare provider should be reported to the School Nurse.
2. Doctor's notes relating to the illness should be provided to the School Nurse who will notify the student's coach and the Athletic Trainer/Athletic Coordinator in the event that the student must be excluded from participation due to illness.

PLEASE KEEP THIS PAGE FOR FUTURE REFERENCE

Sports/Activities Requiring a Sports Physical

Fall Sports/Activities

Football (SH/Mem)
Soccer – Boys/Girls (SH/Mem/LK)
Fall Cheerleading (SH/Mem)
Cross Country – Boys/Girls (SH/Mem/LK)
Tennis – Girls (SH/Mem)
Field Hockey – Girls (SH/Mem/LK)
Weight Training – Boys/Girls (SH/Mem/LK)
Intramurals – Boys/Girls (LK)

Winter Sports/Activities

Wrestling (SH/Mem/LK)
Winter Track (SH/Mem)
Basketball – Boys/Girls (SH/Mem/LK)
Winter Cheerleading (SH/Mem)
Swimming- Boys/Girls (SH/Mem)
Step Team (SH/Mem)
Weight Training – Boys/Girls (SH/Mem/LK)
Ultimate Frisbee – Boys/Girls (SH)
Intramurals – Boys/Girls (LK)

Spring Sports/Activities

Softball – Girls (SH)
Softball – Girls/Boys (LK)
Baseball – Boys (SH/Mem)
Lacrosse – Girls (SH/Mem)
Tennis – Boys (SH/Mem)
Track – Boys/Girls (SH/Mem/LK)
Golf – Boys/Girls (SH/Mem)
Weight Training – Boys/Girls (SH/Mem/LK)
Intramurals – Boys/Girls (LK)

SH = Senior High School

Mem = Memorial High School

LK = Lakeside Middle School

Important Dates:

Fall Sports/Activities: Sports Physical and/or Health History Update Form due: August 4, 2014

Winter Sports/Activities: Sports Physical and/or Health History Update Form due: November 20, 2014

Spring Sports/Activities: Sports Physical and/or Health History Update Form due: February 27, 2015

****If the evaluation is completed more than ninety (90) days prior to the first practice session, the student is required to complete a Health History Update Form ****

PLEASE KEEP THIS PAGE FOR FUTURE REFERENCE

**Millville Public Schools
Interscholastic/Intramural/Club**

PLEASE PRINT CLEARLY:

Name: _____

Student ID#: _____

Date of Birth: _____

Grade (2014-2015 School Year): _____

Sex: M F

Reminder:

All pages that pertain to your child (from this page forward) MUST be completed in their entirety for this physical to be considered complete. If anything is left blank (including but not limited to signatures, dates, etc.) the packet will be returned to the athlete and may cause a delay in physical clearance.

Asthma and Allergy Action Plans must be completed and signed by the treating healthcare provider if this applies to the student athlete.

FOR OFFICE USE ONLY:

SPORTS PHYSICAL DATE: _____

HEALTH HISTORY UPDATE FORM DATE: _____

SPORT(S): _____

IMPACT DATE: _____

MILLVILLE SENIOR HIGH SCHOOL INTERSCHOLASTIC ATHLETIC CONTRACT/AGREEMENT

The following contract has been established to provide communication between the coach, the athlete and the family. The intent of the contract is to try to prevent any misunderstanding about rules and regulations. We ask that both athlete and parent/guardian sign this agreement indicating they have read and will abide by the contract. Participation in interscholastic athletics is a privilege and not a right. Because it is a privilege to represent a school in athletics, it follows logically the school or coach must have the authority to revoke the privilege when the athlete does not conduct himself/herself in an acceptable manner. Not only does this responsibility exist while he/she is participating, but good conduct shall be required of him/her at all times and most certainly while he/she is at school. Athletes are expected to follow the rules of conduct of the district at all times. The athletic program is an extension of the classroom. These will be reviewed by the coaches and will be the athlete's first warning for improper behavior. The coach will maintain communication with parents/guardians at all times should an athlete violate the discipline policy.

RULES OF CONDUCT

1. I will ALWAYS put the TEAM first above my own individual success, and I will respect my coaches' decisions.
2. I will work hard to improve my abilities through weight training conditioning in the off-season and each day in practice.
3. I believe it is a privilege to be an athlete and represent my school in and out of season, as the athletes and coaches before me.
4. I realize that I am more visible than other students. I will avoid parties and other situations that will not allow me to follow the tenets of this contract.
5. I will respect my parents/guardians and coaches by following all team curfews during the season.
6. I will go to practice or the weight room, with a great attitude to "work hard" and "get better" each day.
7. I will do my best at all times as a student and as a law abiding citizen.
8. I will try my best in the classroom always respecting my teachers and having successful academic accomplishments as my foremost high school goals.
9. I recognize my responsibilities if I try out for a sport. I will make it a point to so govern myself that my association with this sport will bring honor to it and the school. I expect to be asked to withdraw from the team in case I do not. I understand the major training rules and regulations that provide the structure needed to best accomplish these purposes. They include, but are not limited to:

A. NO TOBACCO USE

B. NO ALCOHOLIC BEVERAGE USE

C. NO UNAUTHORIZED DRUG CHEMICAL USE

D. NO POLICE FILED CHARGES

All rules, including rules pertaining to drug chemical use, tobacco, and police filed charges, will be applied for one year from the date of the signed contract, or until the student athlete graduates, whichever comes first. (It is not in violation for a student to be in possession of a legally defined drug which is specifically prescribed by the student's personal doctor for the student's own use.)

If a student athlete is found to be in violation of any of the above stated infractions, the head coach will investigate and give due process. If the student athlete is found to be in violation, upon completion of the due process procedure, the coach will discipline or dismiss the student athlete from the squad. If the offense is part of cumulative history, beginning with and throughout the student's participation on a varsity, junior varsity, or freshman team, the athlete may be dismissed from the team. As part of the school discipline procedure, the student athlete must forfeit participation in interscholastic competition (scrimmages are excluded), as directed by the suspension guide. No exception is permitted for a student who becomes a participant in a treatment program. The suspension will commence immediately upon the completion of due process and the determination of the offense by the school administration. The suspension will be applied to the current season, or if out of season, during the next sport that the student participates in. If a student fails to complete a season in which the suspension was applied, the suspension will be applied to the next sport the student athlete goes out for, and so on. In addition, for infractions of a, b, c, d, listed above, the student athlete will be referred to the I. & R. S. Team who will arrive at a recommendation. This recommendation for the student athlete must be followed. Failing to accept and carry out the I. & R. S. Team's recommendation will result in the student athlete not being eligible for team participation in any manner. Also, failing to meet a mandatory parent conference will result in the student athlete not being eligible for team participation in any manner.

After confirmation of a second violation, the student athlete will lose eligibility for interscholastic competition, as per the guide, in increasing increments. No exception is permitted for a student who becomes a participant in a treatment program. Referral will again be made to the I. & R. S. Team and the student athlete's reinstatement will be based on the recommendations and evaluations of the I. & R. S. Team, coach, and administration. If the offense occurs with less games in the season than the penalty, the penalty will carry over to the next, or subsequent season. In addition, penalties may include forfeiture of post-season games, honors, awards, and letters. After a third violation, the student athlete on personal violation, if not dismissed, may be certified for reinstatement for sports activities after a minimum period of six weeks.

1. The students' parents/guardians shall be given a written notice immediately of a violation of the discipline policy.
2. If a student is dropped from a sport, a letter will be forwarded to the athlete, parent/guardian, principal and athletic director.
3. The coach or advisor will review all aspects of the contract with their team prior to the beginning of the season. This will serve as their first warning that these rules will be strictly enforced.
4. When the student is in danger of violating the attendance requirement, he/she will be given a verbal warning, a letter from the coach, and documented on the attendance record.

A Suspension Guide will be invoked in the event of violation of the contract.

I fully agree to abide by the terms of this contract and if I have any problems at any time with these rules I will discuss them with my coaches or a counselor.

I We give our permission for _____
(Please Print Athletes Name)

to participate in organized high school athletics, realizing that such activity involves the potential for injury which is inherent in all sports. I We acknowledge that even with the best coaching and use of the most advanced protective equipment and strict observance of rules, injuries are still a possibility. On rare occasions these injuries can be so serious as to result in total disability, paralysis, or even death. I We acknowledge that I We have read and understand this warning. I We also give permission for information on the physical examination form on our son/daughter to be shared with the following people: coach, trainer, nurse, and administration.

(Signature of Student Athlete)

(Sport)

(Signature of Parent/Guardian)

THESE SIGNATURES INDICATE ACCEPTANCE OF THE CONTRACT _____

(DATE)

Website Resources

- Sudden Death in Athletes
www.cardiachealth.org/sudden-death-in-athletes
- Hypertrophic Cardiomyopathy Association
www.4hcm.org
- American Heart Association www.heart.org

Collaborating Agencies:

American Academy of Pediatrics

New Jersey Chapter

3836 Quakerbridge Road, Suite 108
Hamilton, NJ 08619
(p) 609-842-0014
(f) 609-842-0015
www.aapnj.org



American Heart Association

1 Union Street, Suite 301
Robbinsville, NJ, 08691
(p) 609-208-0020
www.heart.org



New Jersey Department of Education

PO Box 500
Trenton, NJ 08625-0500
(p) 609-292-5935
www.state.nj.us/education/



New Jersey Department of Health

P. O. Box 360
Trenton, NJ 08625-0360
(p) 609-292-7837
www.state.nj.us/health

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SUDDEN CARDIAC DEATH

IN YOUNG ATHLETES

The Basic Facts on Sudden Cardiac Death in Young Athletes

SUDDEN CARDIAC DEATH IN YOUNG ATHLETES

Sudden death in young athletes between the ages of 10 and 19 is very rare. What, if anything, can be done to prevent this kind of tragedy?

What is sudden cardiac death in the young athlete?

Sudden cardiac death is the

result of an unexpected failure of proper heart function, usually (about 60% of the time) during or immediately after exercise without trauma. Since the heart stops pumping adequately, the athlete quickly collapses, loses consciousness, and ultimately dies unless normal heart rhythm is restored using an automated external defibrillator (AED).

How common is sudden death in young athletes?

Sudden cardiac death in young athletes is very rare. About 100 such deaths are reported in the United States per year. The chance of sudden death occurring to any individual high school athlete is about one in 200,000 per year.

Sudden cardiac death is more common: in males than in females; in football and basketball than in other sports; and in African-Americans than in other races and ethnic groups.

What are the most common causes?

Research suggests that the main cause is a loss of proper heart rhythm, causing the heart to quiver instead of pumping blood to the brain and body. This is called ventricular fibrillation (ven-TRICK-you-lar fib-roo-LAY-shun). The problem is usually caused by one of several cardiovascular abnormalities and electrical diseases of the heart that go unnoticed in healthy-appearing athletes.

The most common cause of sudden death in an athlete is hypertrophic cardiomyopathy (hi-per-TRO-fic CAR-dee-oh-my-OP-a-thee) also called HCM. HCM is a disease of the heart, with abnormal thickening of the heart muscle, which can cause serious heart rhythm problems and blockages to blood flow. This genetic disease runs in families and usually develops gradually over many years.

The second most likely cause is congenital (con-JEN-it-ah) (i.e., present from birth) abnormalities of the coronary arteries. This means that these blood vessels are connected to the main blood vessel of the heart in an abnormal way. This differs from blockages that may occur when people get older (commonly called "coronary artery disease," which may lead to a heart attack).



Learn and Live

SUDDEN CARDIAC DEATH IN YOUNG ATHLETES

Other diseases of the heart that can lead to sudden death in young people include:

- Myocarditis (my-oh-car-DIE-tis), an acute inflammation of the heart muscle (usually due to a virus).
- Dilated cardiomyopathy, an enlargement of the heart for unknown reasons.
- Long QT syndrome and other electrical abnormalities of the heart which cause abnormal fast heart rhythms that can also run in families.
- Marfan syndrome, an inherited disorder that affects heart valves, walls of major arteries, eyes and the skeleton. It is generally seen in unusually tall athletes, especially if being tall is not common in other family members.

Are there warning signs to watch for?

In more than a third of these sudden cardiac deaths, there were warning signs that were not reported or taken seriously. Warning signs are:

- Fainting, a seizure or convulsions during physical activity;
- Fainting or a seizure from emotional excitement, emotional distress or being startled;
- Dizziness or lightheadedness, especially during exertion;
- Chest pains, at rest or during exertion;

- Palpitations - awareness of the heart beating unusually (skipping, irregular or extra beats) during athletics or during cool down periods after athletic participation;
- Fatigue or tiring more quickly than peers; or
- Being unable to keep up with friends due to shortness of breath.

What are the current recommendations for screening young athletes?

New Jersey requires all school athletes to be examined by their primary care physician ("medical home") or school physician at least once per year. The New Jersey Department of Education requires use of the specific Annual Athletic Pre-Participation Physical Examination Form.

This process begins with the parents and student-athletes answering questions about symptoms during exercise (such as chest pain, dizziness, fainting, palpitations or shortness of breath); and questions about family health history.

The primary healthcare provider needs to know if any family member died suddenly during physical activity or during a seizure. They also need to know if anyone in the family under the age of 50 had an unexplained sudden death such as drowning or car accidents. This information must be provided annually for each exam because it is so essential to identify those at risk for sudden cardiac death.

The required physical exam includes measurement of blood pressure and a careful listening examination of the heart, especially for murmurs and rhythm abnormalities. If there are no warning signs reported on the health history and no abnormalities discovered on exam, no further evaluation or testing is recommended.

When should a student athlete see a heart specialist?

If the primary healthcare provider or school physician has concerns, a referral to a child heart specialist, a pediatric cardiologist, is recommended. This specialist will perform a more thorough evaluation, including an electrocardiogram (ECG), which is a graph of the electrical activity of the heart. An echocardiogram, which is an ultrasound test to allow for direct visualization of the heart structure, will likely also be done. The specialist may also order a treadmill exercise test and a monitor to enable a longer recording of the heart rhythm. None of the testing is invasive or uncomfortable.

Can sudden cardiac death be prevented just through proper screening?

A proper evaluation should find most, but not all, conditions that would cause sudden death in the athlete. This is because some diseases are difficult to uncover and may only develop later in life. Others can develop following a normal screening evaluation, such as an infection of the heart muscle from a virus.

This is why screening evaluations and a review of the family health history need to be performed on a yearly basis by the athlete's primary healthcare provider. With proper screening and evaluation, most cases can be identified and prevented.

Why have an AED on site during sporting events?

The only effective treatment for ventricular fibrillation is immediate use of an automated external defibrillator (AED). An AED can restore the heart back into a normal rhythm. An AED is also life-saving for ventricular fibrillation caused by a blow to the chest over the heart (commotio cordis).

Effective September 1, 2014, the New Jersey Department of Education requires that all public and nonpublic schools grades K through 12 shall:

- Have an AED available at every sports event (three minutes total time to reach and return with the AED);
- Have adequate personnel who are trained in AED use present at practices and games;
- Have coaches and athletic trainers trained in basic life support techniques (CPR); and
- Call 911 immediately while someone is retrieving the AED.

State of New Jersey
DEPARTMENT OF EDUCATION

**Sudden Cardiac Death Pamphlet
Sign-Off Sheet**

Name of School District: _____

Name of Local School: _____

I/We acknowledge that we received and reviewed the Sudden Cardiac Death in Young Athletes pamphlet.

Student Signature: _____

Parent or Guardian
Signature: _____

Date: _____



1161 Route 130, P.O. Box 487, Robbinsville, NJ 08691 609-259-2776 609-259-3047-Fax

NJSIAA STEROID TESTING POLICY

CONSENT TO RANDOM TESTING

In Executive Order 72, issued December 20, 2005, Governor Richard Codey directed the New Jersey Department of Education to work in conjunction with the New Jersey State Interscholastic Athletic Association (NJSIAA) to develop and implement a program of random testing for steroids, of teams and individuals qualifying for championship games.

Beginning in the Fall, 2006 sports season, any student-athlete who possesses, distributes, ingests or otherwise uses any of the banned substances on the attached page, without written prescription by a fully-licensed physician, as recognized by the American Medical Association, to treat a medical condition, violates the NJSIAA's sportsmanship rule, and is subject to NJSIAA penalties, including ineligibility from competition. The NJSIAA will test certain randomly selected individuals and teams that qualify for a state championship tournament or state championship competition for banned substances. The results of all tests shall be considered confidential and shall only be disclosed to the student, his or her parents and his or her school. No student may participate in NJSIAA competition unless the student and the student's parent/guardian consent to random testing.

By signing below, we consent to random testing in accordance with the NJSIAA steroid testing policy. We understand that, if the student or the student's team qualifies for a state championship tournament or state championship competition, the student may be subject to testing for banned substances.

Signature of Student-Athlete

Print Student-Athlete's Name

Date

Signature of Parent/Guardian

Print Parent/Guardian's Name

Date

2014-15 NJSIAA Banned Drugs

IT IS YOUR RESPONSIBILITY TO CHECK WITH THE APPROPRIATE OR DESIGNATED ATHLETICS STAFF BEFORE USING ANY SUBSTANCE

The NJSIAA bans the following classes of drugs:

- Stimulants
- Anabolic Agents
- Alcohol and Beta Blockers (banned for rifle only)
- Diuretics and Other Masking Agents
- Street Drugs
- Peptide Hormones and Analogues
- Anti-estrogens
- Beta-2 Agonists

Note: Any substance chemically related to these classes is also banned.

THE INSTITUTION AND THE STUDENT-ATHLETE SHALL BE HELD ACCOUNTABLE FOR ALL DRUGS WITHIN THE BANNED DRUG CLASS REGARDLESS OF WHETHER THEY HAVE BEEN SPECIFICALLY IDENTIFIED.

Drugs and Procedures Subject to Restrictions

- Blood Doping
- Local Anesthetics (under some conditions)
- Manipulation of Urine Samples
- Beta-2 Agonists permitted only by prescription and inhalation
- Caffeine if concentrations in urine exceed 15 micrograms/ml

NJSIAA Nutritional/Dietary Supplements Warning

Before consuming any nutritional/dietary supplement product, review the product with the appropriate or designated athletics department staff!

- Dietary supplements are not well regulated and may cause a positive drug test result.
- Student-athletes have tested positive and lost their eligibility using dietary supplements.
- Many dietary supplements are contaminated with banned drugs not listed on the label.
- Any product containing a dietary supplement ingredient is taken at your own risk.

NOTE TO STUDENT-ATHLETES: THERE IS NO COMPLETE LIST OF BANNED SUBSTANCES. DO NOT RELY ON THIS LIST TO RULE OUT ANY SUPPLEMENT INGREDIENT. CHECK WITH YOUR ATHLETICS DEPARTMENT STAFF PRIOR TO USING A SUPPLEMENT.

Some Examples of NJSIAA Banned Substances in Each Drug Class

Stimulants

Amphetamine (Adderall); caffeine (guarana); cocaine; ephedrine; fenfluramine (Fen); methamphetamine; methylphenidate (Ritalin); phentermine (Phen); synephrine (bitter orange); methylhexanamine, "bath salts" (mephedrone) etc.

exceptions: phenylephrine and pseudoephedrine are not banned.

Anabolic Agents (sometimes listed as a chemical formula, such as 3,6,17-androstenetrione)

Androstenedione; boldenone; clenbuterol; DHEA (7-Keto); epi-trenbolone; etiocholanolone; methasterone; methandienone; nandrolone; norandrostenedione; stanozolol; stenbolone; testosterone; trenbolone; etc.

Alcohol and Beta Blockers (banned for rifle only)

Alcohol; atenolol; metoprolol; nadolol; pindolol; propranolol; timolol; etc.

Diuretics (water pills) and Other Masking Agents

Bumetanide; chlorothiazide; furosemide; hydrochlorothiazide; probenecid; spironolactone (canrenone); triameterene; trichlormethiazide; etc.

Street Drugs

Heroin; marijuana; tetrahydrocannabinol (THC); synthetic cannabinoids (eg. spice, K2, JWH-018, JWH-073)

Peptide Hormones and Analogues

Growth hormone(hGH); human chorionic gonadotropin (hCG); erythropoietin (EPO); etc.

Anti-Estrogens

Anastrozole; tamoxifen; formestane; 3,17-dioxo-etiochol-1,4,6-triene(ATD), etc.

Beta-2 Agonists

Bambuterol; formoterol; salbutamol; salmeterol; etc.

ANY SUBSTANCE THAT IS CHEMICALLY RELATED TO THE CLASS, EVEN IF IT IS NOT LISTED AS AN EXAMPLE, IS ALSO BANNED! IT IS YOUR RESPONSIBILITY TO CHECK WITH THE APPROPRIATE OR DESIGNATED ATHLETICS STAFF BEFORE USING ANY SUBSTANCE.

Sports-Related Concussion and Head Injury Fact Sheet and Parent/Guardian Acknowledgement Form

A concussion is a brain injury that can be caused by a blow to the head or body that disrupts normal functioning of the brain. Concussions are a type of Traumatic Brain Injury (TBI), which can range from mild to severe and can disrupt the way the brain normally functions. Concussions can cause significant and sustained neuropsychological impairment affecting problem solving, planning, memory, attention, concentration, and behavior.

The Centers for Disease Control and Prevention estimates that 300,000 concussions are sustained during sports related activities nationwide, and more than 62,000 concussions are sustained each year in high school contact sports. Second-impact syndrome occurs when a person sustains a second concussion while still experiencing symptoms of a previous concussion. It can lead to severe impairment and even death of the victim.

Legislation (P.L. 2010, Chapter 94) signed on December 7, 2010, mandated measures to be taken in order to ensure the safety of K-12 student-athletes involved in interscholastic sports in New Jersey. It is imperative that athletes, coaches, and parent/guardians are educated about the nature and treatment of sports related concussions and other head injuries. The legislation states that:

- All Coaches, Athletic Trainers, School Nurses, and School/Team Physicians shall complete an Interscholastic Head Injury Safety Training Program by the 2011-2012 school year.
- All school districts, charter, and non-public schools that participate in interscholastic sports will distribute annually this educational fact to all student athletes and obtain a signed acknowledgement from each parent/guardian and student-athlete.
- Each school district, charter, and non-public school shall develop a written policy describing the prevention and treatment of sports-related concussion and other head injuries sustained by interscholastic student-athletes.
- Any student-athlete who participates in an interscholastic sports program and is suspected of sustaining a concussion will be immediately removed from competition or practice. The student-athlete will not be allowed to return to competition or practice until he/she has written clearance from a physician trained in concussion treatment and has completed his/her district's graduated return-to-play protocol.

Quick Facts

- Most concussions do not involve loss of consciousness
- You can sustain a concussion even if you do not hit your head
- A blow elsewhere on the body can transmit an "impulsive" force to the brain and cause a concussion

Signs of Concussions (Observed by Coach, Athletic Trainer, Parent/Guardian)

- Appears dazed or stunned
- Forgets plays or demonstrates short term memory difficulties (e.g. unsure of game, opponent)
- Exhibits difficulties with balance, coordination, concentration, and attention
- Answers questions slowly or inaccurately
- Demonstrates behavior or personality changes
- Is unable to recall events prior to or after the hit or fall

Symptoms of Concussion (Reported by Student-Athlete)

- Headache
- Nausea/vomiting
- Balance problems or dizziness
- Double vision or changes in vision
- Sensitivity to light/sound
- Feeling of sluggishness or fogginess
- Difficulty with concentration, short term memory, and/or confusion

What Should a Student-Athlete do if they think they have a concussion?

- **Don't hide it.** Tell your Athletic Trainer, Coach, School Nurse, or Parent/Guardian.
- **Report it.** Don't return to competition or practice with symptoms of a concussion or head injury. The sooner you report it, the sooner you may return-to-play.
- **Take time to recover.** If you have a concussion your brain needs time to heal. While your brain is healing you are much more likely to sustain a second concussion. Repeat concussions can cause permanent brain injury.

What can happen if a student-athlete continues to play with a concussion or returns to play too soon?

- Continuing to play with the signs and symptoms of a concussion leaves the student-athlete vulnerable to second impact syndrome.
- Second impact syndrome is when a student-athlete sustains a second concussion while still having symptoms from a previous concussion or head injury.
- Second impact syndrome can lead to severe impairment and even death in extreme cases.

Should there be any temporary academic accommodations made for Student-Athletes who have suffered a concussion?

- To recover cognitive rest is just as important as physical rest. Reading, texting, testing-even watching movies can slow down a student-athletes recovery.
- Stay home from school with minimal mental and social stimulation until all symptoms have resolved.
- Students may need to take rest breaks, spend fewer hours at school, be given extra time to complete assignments, as well as being offered other instructional strategies and classroom accommodations.

Student-Athletes who have sustained a concussion should complete a graduated return-to-play before they may resume competition or practice, according to the following protocol:

- **Step 1:** Completion of a full day of normal cognitive activities (school day, studying for tests, watching practice, interacting with peers) without reemergence of any signs or symptoms. If no return of symptoms, next day advance.
- **Step 2:** Light Aerobic exercise, which includes walking, swimming, and stationary cycling, keeping the intensity below 70% maximum heart rate. No resistance training. The objective of this step is increased heart rate.
- **Step 3:** Sport-specific exercise including skating, and/or running: no head impact activities. The objective of this step is to add movement.
- **Step 4:** Non contact training drills (e.g. passing drills). Student-athlete may initiate resistance training.
- **Step 5:** Following medical clearance (consultation between school health care personnel and student-athlete's physician), participation in normal training activities. The objective of this step is to restore confidence and assess functional skills by coaching and medical staff.
- **Step 6:** Return to play involving normal exertion or game activity.

For further information on Sports-Related Concussions and other Head Injuries, please visit:

www.cdc.gov/concussion/sports/index.html

www.nfhs.com

www.ncaa.org/health-safety

www.bianj.org

www.atSNJ.org

Signature of Student-Athlete

Print Student-Athlete's Name

Date

Signature of Parent/Guardian

Print Parent/Guardian's Name

Date

Asthma Treatment Plan – Student

(This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.8) (Physician's Orders)

The Pediatric/Adult
Asthma Coalition
of New Jersey
"Your Pathway to Asthma Control"
PACNJ approved Plan available at
www.pacnj.org

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(Please Print)

Name		Date of Birth	Effective Date
Doctor	Parent/Guardian (if applicable)		Emergency Contact
Phone	Phone		Phone

HEALTHY (Green Zone) ||||



You have all of these:

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

Take daily control medicine(s). Some inhalers may be more effective with a "spacer" – use if directed.

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
<input type="checkbox"/> Advair® HFA <input type="checkbox"/> 45, <input type="checkbox"/> 115, <input type="checkbox"/> 230	2 puffs twice a day
<input type="checkbox"/> Alvesco® <input type="checkbox"/> 80, <input type="checkbox"/> 160	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day
<input type="checkbox"/> Dulera® <input type="checkbox"/> 100, <input type="checkbox"/> 200	2 puffs twice a day
<input type="checkbox"/> Flovent® <input type="checkbox"/> 44, <input type="checkbox"/> 110, <input type="checkbox"/> 220	2 puffs twice a day
<input type="checkbox"/> Qvar® <input type="checkbox"/> 40, <input type="checkbox"/> 80	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day
<input type="checkbox"/> Symbicort® <input type="checkbox"/> 80, <input type="checkbox"/> 160	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day
<input type="checkbox"/> Advair Diskus® <input type="checkbox"/> 100, <input type="checkbox"/> 250, <input type="checkbox"/> 500	1 inhalation twice a day
<input type="checkbox"/> Asmanex® Twisthaler® <input type="checkbox"/> 110, <input type="checkbox"/> 220	<input type="checkbox"/> 1, <input type="checkbox"/> 2 inhalations <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Flovent® Diskus® <input type="checkbox"/> 50 <input type="checkbox"/> 100 <input type="checkbox"/> 250	1 inhalation twice a day
<input type="checkbox"/> Pulmicort Flexhaler® <input type="checkbox"/> 90, <input type="checkbox"/> 180	<input type="checkbox"/> 1, <input type="checkbox"/> 2 inhalations <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Pulmicort Respules® (Budesonide) <input type="checkbox"/> 0.25, <input type="checkbox"/> 0.5, <input type="checkbox"/> 1.0	1 unit nebulized <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Singulair® (Montelukast) <input type="checkbox"/> 4, <input type="checkbox"/> 5, <input type="checkbox"/> 10 mg	1 tablet daily
<input type="checkbox"/> Other	
<input type="checkbox"/> None	

And/or Peak flow above _____

Remember to rinse your mouth after taking inhaled medicine.
If exercise triggers your asthma, take this medicine _____ minutes before exercise.

Triggers

Check all items that trigger patient's asthma:

- Colds/flu
- Exercise
- Allergens
 - o Dust Mites, dust, stuffed animals, carpet
 - o Pollen - trees, grass, weeds
 - o Mold
 - o Pets - animal dander
 - o Pests - rodents, cockroaches
- Odors (Irritants)
 - o Cigarette smoke & second hand smoke
 - o Perfumes, cleaning products, scented products
 - o Smoke from burning wood, inside or outside
- Weather
 - o Sudden temperature change
 - o Extreme weather - hot and cold
 - o Ozone alert days
- Foods:
 - o _____
 - o _____
 - o _____

CAUTION (Yellow Zone) ||||



You have any of these:

- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other: _____

If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.

And/or Peak flow from _____ to _____

Continue daily control medicine(s) and ADD quick-relief medicine(s).

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
<input type="checkbox"/> Combivent® <input type="checkbox"/> Maxair® <input type="checkbox"/> Xopenex®	2 puffs every 4 hours as needed
<input type="checkbox"/> Ventolin® <input type="checkbox"/> Pro-Air® <input type="checkbox"/> Proventil®	2 puffs every 4 hours as needed
<input type="checkbox"/> Albuterol <input type="checkbox"/> 1.25, <input type="checkbox"/> 2.5 mg	1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Duoneb®	1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Xopenex® (Levalbuterol) <input type="checkbox"/> 0.31, <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg	1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Increase the dose of, or add:	
<input type="checkbox"/> Other	

• If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.

EMERGENCY (Red Zone) ||||



Your asthma is getting worse fast:

- Quick-relief medicine did not help within 15-20 minutes
- Breathing is hard or fast
- Nose opens wide • Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue
- Other: _____

And/or Peak flow below _____

Take these medicines NOW and CALL 911. Asthma can be a life-threatening illness. Do not wait!

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
<input type="checkbox"/> Combivent® <input type="checkbox"/> Maxair® <input type="checkbox"/> Xopenex®	2 puffs every 20 minutes
<input type="checkbox"/> Ventolin® <input type="checkbox"/> Pro-Air® <input type="checkbox"/> Proventil®	2 puffs every 20 minutes
<input type="checkbox"/> Albuterol <input type="checkbox"/> 1.25, <input type="checkbox"/> 2.5 mg	1 unit nebulized every 20 minutes
<input type="checkbox"/> Duoneb®	1 unit nebulized every 20 minutes
<input type="checkbox"/> Xopenex® (Levalbuterol) <input type="checkbox"/> 0.31, <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg	1 unit nebulized every 20 minutes
<input type="checkbox"/> Other	

This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.

Disclaimer: This asthma action plan is intended to assist in the management of asthma. It is not a substitute for medical advice from a healthcare provider. The user should consult with a healthcare provider for more information. This form is provided as a service to the public and is not intended to be used for legal purposes. © 2012 PACNJ. All rights reserved.

Permission to Self-administer Medication:

- This student is capable and has been instructed in the proper method of self-administering of the non-nebulized inhaled medications named above in accordance with NJ Law.
- This student is not approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE _____

PHYSICIAN STAMP

Make a copy for parent and for physician file, send original to school nurse or child care provider.

PARENT/GUARDIAN SIGNATURE REQUIRED ON BACK

Asthma Treatment Plan – Student Parent Instructions



The **PACNJ Asthma Treatment Plan** is designed to help everyone understand the steps necessary for the individual student to achieve the goal of controlled asthma.

- Parents/Guardians:** Before taking this form to your Health Care Provider, complete the top left section with:
 - Child's name
 - Child's doctor's name & phone number
 - Parent/Guardian's name & phone number
 - Child's date of birth
 - An Emergency Contact person's name & phone number
- Your Health Care Provider will** complete the following areas:
 - The effective date of this plan
 - The medicine information for the Healthy, Caution and Emergency sections
 - Your Health Care Provider will check the box next to the medication and check how much and how often to take it
 - Your Health Care Provider may check **"OTHER"** and:
 - ❖ Write in asthma medications not listed on the form
 - ❖ Write in additional medications that will control your asthma
 - ❖ Write in generic medications in place of the name brand on the form
 - Together you and your Health Care Provider will decide what asthma treatment is best for your child to follow
- Parents/Guardians & Health Care Providers together** will discuss and then complete the following areas:
 - Child's peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
 - Child's asthma triggers on the right side of the form
 - Permission to Self-administer Medication section at the bottom of the form: Discuss your child's ability to self-administer the inhaled medications, check the appropriate box, and then both you and your Health Care Provider must sign and date the form
- Parents/Guardians:** After completing the form with your Health Care Provider:
 - Make copies of the Asthma Treatment Plan and give the signed original to your child's school nurse or child care provider
 - Keep a copy easily available at home to help manage your child's asthma
 - Give copies of the Asthma Treatment Plan to everyone who provides care for your child, for example: babysitters, before/after school program staff, coaches, scout leaders

PARENT AUTHORIZATION

I hereby give permission for my child to receive medication at school as prescribed in the Asthma Treatment Plan. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications. In addition, I understand that this information will be shared with school staff on a need to know basis.

Parent/Guardian Signature

Phone

Date

STUDENT AUTHORIZATION FOR SELF ADMINISTRATION OF ASTHMA MEDICATION

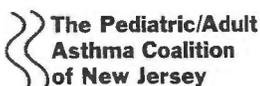
RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

- I do request that my child be **ALLOWED** to carry the following medication _____ for self-administration in school pursuant to N.J.A.C.:6A:16-2.3. I give permission for my child to self-administer medication, as prescribed in this Asthma Treatment Plan for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. Medication must be kept in its original prescription container. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.
- I **DO NOT** request that my child self-administer his/her asthma medication.

Parent/Guardian Signature

Phone

Date



"Your Pathway to Asthma Control"
PACNJ approved Plan available at
www.pacnj.org

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IN NEW JERSEY

Millville Public Schools - Allergy Action Plan

Student's Name: _____ D.O.B: _____ Teacher/Homeroom: _____

ALLERGY TO: _____

Asthmatic: Yes * No Higher risk for severe reaction

STEP 1 : PREVENTION

Avoid contact with: _____ ingestion inhaled skin contact other: _____

The following foods may be substituted: _____

Preferential seating in the cafeteria, No Yes Describe: _____

Preferential seating on the school bus, No Yes Describe: _____

STEP 2: TREATMENT

Symptoms:

Contact with allergen but *no symptoms*:
Mouth Itching, tingling, or swelling of lips, tongue, mouth
Skin Hives, itchy rash, swelling of the face or extremities
Gut Nausea, abdominal cramps, vomiting, diarrhea
Throat Tightening of throat, hoarseness, hacking cough
Lung Shortness of breath, repetitive coughing, wheezing
Heart Thready pulse, low blood pressure, fainting, pale, blueness
Other _____

If reaction is progressing (several of the above areas affected), give:

Give Checked Medication:

(To be determined by healthcare provider authorizing treatment)

Epinephrine	Antihistamine

Dosage:

Epinephrine: inject intramuscularly (circle one): EpiPen® EpiPen®Jr. Twinject™ 0.15 mg

Antihistamine: give: _____
(medication dose route)

Other: _____
(medication dose route)

To be completed by the ordering physician:

This student is capable and has been instructed in the proper method of self-administering the medications named above.

This student is not approved to self-medicate.

Doctor's Signature: _____ Date: _____

STEP 3: EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. _____ at _____
3. Emergency contacts: To be completed by parent/guardian.

Name/Relationship	Phone number(s)
a. _____	1. _____ 2. _____
b. _____	1. _____ 2. _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, MEDICATE AND TRANSPORT STUDENT TO A MEDICAL FACILITY

I have read and understand the Allergy Action Plan created for my child. I understand that it will be shared verbally and/or in writing with school personnel involved with my child. We acknowledge that the Millville Public Schools and its employees and agents shall incur no liability as a result of any injury arising from self-administration of medication by the student. We agree to indemnify and hold harmless the school district and its employees and agents against any claims arising from self-administration of life-saving medication by the student.

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? Yes No If yes, please identify specific allergy below.

Medicines Pollens Food Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____			27. Have you ever used an inhaler or taken asthma medicine?		
3. Have you ever spent the night in the hospital?			28. Is there anyone in your family who has asthma?		
4. Have you ever had surgery?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	30. Do you have groin pain or a painful bulge or hernia in the groin area?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			31. Have you had infectious mononucleosis (mono) within the last month?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			32. Do you have any rashes, pressure sores, or other skin problems?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			33. Have you had a herpes or MRSA skin infection?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____			34. Have you ever had a head injury or concussion?		
9. Has a doctor ever ordered a test for your heart? (For example ECG/EKG echocardiogram)			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?			36. Do you have a history of seizure disorder?		
11. Have you ever had an unexplained seizure?			37. Do you have headaches with exercise?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	39. Have you ever been unable to move your arms or legs after being hit or falling?		
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?			40. Have you ever become ill while exercising in the heat?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?			41. Do you get frequent muscle cramps when exercising?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			42. Do you or someone in your family have sickle cell trait or disease?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			43. Have you had any problems with your eyes or vision?		
BONE AND JOINT QUESTIONS	Yes	No	44. Have you had any eye injuries?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			45. Do you wear glasses or contact lenses?		
18. Have you ever had any broken or fractured bones or dislocated joints?			46. Do you wear protective eyewear, such as goggles or a face shield?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			47. Do you worry about your weight?		
20. Have you ever had a stress fracture?			48. Are you trying to or has anyone recommended that you gain or lose weight?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)			49. Are you on a special diet or do you avoid certain types of foods?		
22. Do you regularly use a brace, orthotics, or other assistive device?			50. Have you ever had an eating disorder?		
23. Do you have a bone, muscle, or joint injury that bothers you?			51. Do you have any concerns that you would like to discuss with a doctor?		
24. Do any of your joints become painful, swollen, feel warm, or look red?			FEMALES ONLY		
25. Do you have any history of juvenile arthritis or connective tissue disease?			52. Have you ever had a menstrual period?		
			53. How old were you when you had your first menstrual period?		
			54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

PREPARTICIPATION PHYSICAL EVALUATION

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION			
Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female	
BP / /	(/)	Pulse	Vision R 20/ L 20/ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS	
Appearance <ul style="list-style-type: none"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) 			
Eyes/ears/nose/throat <ul style="list-style-type: none"> Pupils equal Hearing 			
Lymph nodes			
Heart ^a <ul style="list-style-type: none"> Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI) 			
Pulses <ul style="list-style-type: none"> Simultaneous femoral and radial pulses 			
Lungs			
Abdomen			
Genitourinary (males only) ^b			
Skin <ul style="list-style-type: none"> HSV, lesions suggestive of MRSA, tinea corporis 			
Neurologic ^c			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional <ul style="list-style-type: none"> Duck-walk, single leg hop 			

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
^bConsider GU exam if in private setting. Having third party present is recommended.
^cConsider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____
- Not cleared
- Pending further evaluation
 - For any sports
 - For certain sports _____
- Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type) _____ Date _____
 Address _____ Phone _____
 Signature of physician, APN, PA _____

■ PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Name _____ Sex M F Age _____ Date of birth _____

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

- Not cleared
- Pending further evaluation
 - For any sports
 - For certain sports _____
- Reason _____

Recommendations _____

EMERGENCY INFORMATION

Allergies _____

Other information _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) _____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____

Completed Cardiac Assessment Professional Development Module

Date _____ Signature _____